Public Funding for MH/MR/DD/BI Services 2001-2005
Observations and Perceptions from DHS, ISAC, and LSA Concerning the Data

A. Caveats and Assumptions.
   1. This data presentation is an attempt to aggregate for the first time all of the major funding sources currently utilized in the MH/MR/DD/BI services system: federal, state, county, and client participation. Because the data comes from various sources that have been adjusted in an effort to eliminate duplication, the figures presented should be considered an initial approximation. The SSI and SSA amounts are estimates derived from federal reports.
   2. It is anticipated that policymakers will want to know how many people received benefits from the funding identified. The data system now being implemented should improve the accuracy of this data. Until then, it is not possible to provide a very accurate unduplicated count using the available state and county data and a federal SSI count is not available at all. Here is a rough approximation for FY 2004-2005 (without any SSI cases counted), based on the number of clients who received a service at some point during that fiscal year :

County Cases:	45,206
SPP Cases:	2,931
Total:	48,137

B. General Observations
   1. The overall amount of funding committed to these services, numbers of persons receiving Medicaid services, and numbers of services provided have all substantially increased over the period.
   2. County funding has been capped and the rate of the state funding of growth has been controlled. Consequently, the most significant source for funding growth is related to the expanded use of the Medicaid program, with the leverage of a federal funding match (usually about two thirds of the cost of the service is paid by federal money).
   3. The Medicaid Program expenditures are consuming an increasingly larger portion of overall expenditures.
   4. The original allocation of property tax relief funding to counties was not equitable (i.e., two counties of similar size received 33 percent and 66 percent of their MH/DD budgets in property tax relief.). The allocation was based upon a county's proportion of the following: the state's general population, the state's total taxable property valuation assessed for taxes, and all counties' base year expenditures for these services.
   5. The rate of participation and amount of funding committed to Medicaid waiver programs have increased substantially over time.
   6. The largest proportion of the funding is committed to residential costs.
   7. Costs and cost increases are related to the numbers of persons who receive services, the quantity of services provided, and the amount of reimbursement paid for the services. Expanded use of Medicaid has expanded all three categories.
   8. The reimbursement rates paid for Medicaid services have an effect on the reimbursement rates paid for non-Medicaid services.

9. In the early years, counties were concerned about having enough capacity to fund any obligations the county might have. For small counties, the impact of a costly person was always a consideration.
10. In the beginning of FY 1996-1997, each county was authorized to deposit money into the county's MH/MR/DD Services Fund (up to about 40 percent of the budgeted expenditures) from the county's General Fund so the fund would not run in the red or the county would not have to borrow from another fund.
11. Most counties chose the higher of the two options provided to use as the basis for the county MH/MR/DD Services Fund limitation (actual FY 1993-1994 expenditures or budgeted FY 1995-996 expenditures).
12. During the past six years, counties have been provided incentives to buy down their fund balances in order to receive the state's Allowed Growth Allocations.

C. Medicaid Observations
1. The expansion of Medicaid waiver services has not resulted in a significant reduction in expenditures for institutional residential services or institutional beds.
2. In general, Medicaid does not provide for all the services needed by an individual, non-Medicaid services are needed as well.
3. Services currently receiving significant non-Medicaid funding include activities associated with civil commitment, residential care facilities, transportation, therapy, and sheltered workshops. Although some of these services are not Medicaid mandates, many are mandated by Iowa law or comprise a de facto mandate.
4. The usage of the Medicaid Program requires an acceptance of the federal requirements for the program.
5. The entitlement nature of the Medicaid Program means that once a person becomes eligible, as long as the person's eligibility and need for services continues, the financial commitment for the services continues as well.
6. With Medicaid services, so long as costs are justified, the counties or, to a lesser degree, the state providing the match funding have limited ability to control costs.
7. Many persons with significant MH or disability needs are not eligible for Medicaid and are supported with non-Medicaid funds.
8. As long as county funding remains capped and the rate of state funding growth is controlled, funding currently committed to non-Medicaid services will have to be shifted to support Medicaid services.
9. Although a county can temporarily control waiver slots by applying a waiting list, after a period of time the statewide nature of the waiver programs results in another county's excess slot becoming available to the waiting list county in time.

D. Perceptions
1. Even though the quantities of funding and services provided have all increased, there is significant concern that the rise in demand will outstrip ability to provide funding to meet that demand.

2. There is a multitude of funding sources used for the services in the system. Each year it seems as though the requirements change for one or more of the funding sources, causing anxiety and difficulties in this system. Current examples:
   a. The upcoming Medicaid changes from the Adult Rehabilitation Option to remedial services.
   b. Iowa Vocational Rehabilitative Services (IVRS) is refusing supported employment funding to individuals who are eligible for a Medicaid home and community-based services waiver. Counties are responsible for the non-federal share of this services when it is provided through a Medicaid waiver and do not pay when IVRS provides the services
3. The future is uncertain.
4. Community and consumer expectations for the types and quality level of publicly supported services have risen significantly over the last decade and are likely to continue to increase. Consumers have become much more engaged in determining how services are provided.
5. Under the current funding structure, counties that have no or slow population growth may have a better ability to address expenditure increases than counties with steady or strong growth.
6. Under the current funding structure, counties with strong valuation increases have a steadily declining portion of their property tax rates dedicated to MH/DD services and the reverse is true for counties with stagnant valuation increases.